

Claims Appeal & Dispute Form

Provider Information ☐ INN ☐ OON		Contact Information	
Provider/Group Name:		Name:	
Tax ID or NPI:		Address:	
Patient Information ☐ HMO ☐ PPO		Phone #: ()	
Patient Name:		Fax #: ()	
Member ID: CP _____		Contact Information	
Attachments		Claim Number:	
Remittance Advice ☐ Medical Records ☐		Date of Determination* ____ / ____ / ____	
Supporting Documentation for Dispute ☐		Date(s) of Service: ____ / ____ / ____	
Waiver of Liability (REQUIRED for OON) ☐		____ / ____ / ____	
Reason for Dispute (Please Select One)			
Overpayment ☐ Underpayment** ☐ Denial Code(s) ☐ _____			
Amount Paid: \$ _____ Expected Amount: \$ _____			
Whole Claim: ☐ CPT Code(s): ☐ _____			
Other (Please provide a description)			
Return Information			
INN providers should submit requests to: Mail: PO Box 2092 Jersey City, NJ 07303 Fax: 1-888-240-7243 Secure Email: PO_Box_2092@cloverhealth.com		OON providers should submit requests to: Mail: PO Box 2091 Jersey City, NJ 07303 Fax: 1-732-412-9706 Secure Email: PO_Box_2091@cloverhealth.com	

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